SERFF Tracking Number:	*ANTX-126722485*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*46508*
Company Tracking Number:	*SLA-HI10(AR)*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*SLAICO HIP (AR)*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Standard Life and Accident Insurance Company

Product Name: SLAICO HIP (AR)	SERFF Tr Num: ANTX-126722485	State: Arkansas
TOI: H14I Individual Health - Hospital Indemnity	SERFF Status: Closed-Approved-Closed	State Tr Num: 46508
Sub-TOI: H14I.000 Health - Hospital Indemnity	Co Tr Num: SLA-HI10(AR)	State Status: Approved-Closed
Filing Type: Form/Rate		Reviewer(s): Rosalind Minor
	Authors: Deborah Biediger, Patty Clavette	Disposition Date: 08/27/2010
	Date Submitted: 08/15/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile: 06/29/2010
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 08/27/2010	Explanation for Other Group Market Type:
	State Status Changed: 08/27/2010
Deemer Date:	Created By: Patty Clavette
Submitted By: Patty Clavette	Corresponding Filing Tracking Number:

Filing Description:

Attached is Hospital Confinement Policy SLA-HI 10(AR), et. al.

This Policy will be marketed to Applicants from the ages of 18-74.

The standard NAIC "Guide to Health Insurance for People with Medicare" will be provided for any Medicare eligible applicants at the time of solicitation as well as the statutorily required Medicare Duplication Notice and Replacement of Insurance Notice.

SERFF Tracking Number:	*ANTX-126722485*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*46508*
Company Tracking Number:	*SLA-HI10(AR)*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*SLAICO HIP (AR)*		
Project Name/Number:	*/*		

Company and Contact

Filing Contact Information

Patty Clavette, Sr Compliance Analyst
One Moody Plaza 17th Floor
Galveston, TX 77550

patty.clavette@anico.com
225-677-9015 [Phone]
409-766-2080 [FAX]

Filing Company Information

Standard Life and Accident Insurance Company
One Moody Plaza, SSH MP, Ste. 200
Galveston, TX 77550
(281) 538-4842 ext. [Phone]

CoCode: 86355
Group Code: 408
Group Name:
FEIN Number: 73-0994234

State of Domicile: Texas
Company Type: Health Insurance
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$150.00
Retaliatory?	No
Fee Explanation:	Retaliatory would be $100. AR fee is $150 at 3 forms x $50/form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Life and Accident Insurance Company	$150.00	08/15/2010	38787246

SERFF Tracking Number:	*ANTX-126722485*	*State:*	*Arkansas*
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Product Name:	*SLAICO HIP (AR)*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/27/2010	08/27/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	08/19/2010	08/19/2010	Patty Clavette	08/23/2010	08/23/2010

SERFF Tracking Number:	*ANTX-126722485*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*46508*
Company Tracking Number:	*SLA-HI10(AR)*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*SLAICO HIP (AR)*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 08/27/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ANTX-126722485*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*46508*
Company Tracking Number:	*SLA-HI10(AR)*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*SLAICO HIP (AR)*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Arkansas Notice	Approved-Closed	Yes
Supporting Document	Third Party Authorization	Approved-Closed	Yes
Form *(revised)*	Hospital Confinement Policy	Approved-Closed	Yes
Form	Hospital Confinement Policy	Replaced	Yes
Form	Application	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Rate	Rates	Approved-Closed	Yes

SERFF Tracking Number:	*ANTX-126722485*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*46508*
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Product Name:	*SLAICO HIP (AR)*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	08/19/2010
Submitted Date	08/19/2010
Respond By Date	

Dear Patty Clavette,

This will acknowledge receipt of the captioned filing.

Objection 1

- Hospital Confinement Policy, SLA-HI 10(AR) (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-85-131(b) and Bulletin 14-81.

Objection 2

- Hospital Confinement Policy, SLA-HI 10(AR) (Form)

Comment:

There needs to be a provision for the refund of unearned premium in the event of death of the insured. Refer to ACA 23-85-134.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number:	*ANTX-126722485*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*46508*
Company Tracking Number:	*SLA-HI10(AR)*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*SLAICO HIP (AR)*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	08/23/2010
Submitted Date	08/23/2010

Dear Rosalind Minor,

Comments:
Thank you for your response.

Response 1

Comments: I have revised the wording for handicapped dependents to no longer include time limits.

Related Objection 1

Applies To:

- Hospital Confinement Policy, SLA-HI 10(AR) (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-85-131(b) and Bulletin 14-81.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Hospital Confinement Policy	SLA-HI 10(AR)		Policy/Contract/Fraternal Certificate	Initial			Policy_AR_Aug 21 2010.pdf
Previous Version							
Hospital Confinement Policy	*SLA-HI 10(AR)*		*Policy/Contract/Fraternal Certificate*	*Initial*			Policy_AR_Aug 15

2010.pdf

No Rate/Rule Schedule items changed.

Response 2

Comments: I have added a Refund of Unearned Premium provision to the General Provisions.

Related Objection 1

Applies To:

- Hospital Confinement Policy, SLA-HI 10(AR) (Form)

Comment:

There needs to be a provision for the refund of unearned premium in the event of death of the insured. Refer to ACA 23-85-134.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Hospital Confinement Policy	SLA-HI 10(AR)		Policy/Contract/Fraternal Certificate	Initial			Policy_AR_Aug 21 2010.pdf
Previous Version							
Hospital Confinement Policy	*SLA-HI 10(AR)*		*Policy/Contract/Fraternal Certificate*	*Initial*			Policy_AR_Aug 15 2010.pdf

No Rate/Rule Schedule items changed.

Thank you for your review.

Sincerely,

SERFF Tracking Number:	*ANTX-126722485*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*46508*
Company Tracking Number:	*SLA-HI10(AR)*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*SLAICO HIP (AR)*		
Project Name/Number:	*/*		

Deborah Biediger, Patty Clavette

SERFF Tracking Number:	*ANTX-126722485*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*46508*
Company Tracking Number:	*SLA-HI10(AR)*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*SLAICO HIP (AR)*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: SLA-HI10(AR)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/27/2010	SLA-HI 10(AR)	Policy/Contract/Fraternal Certificate	Hospital Confinement Policy	Initial			Policy_AR_Aug 21 2010.pdf
Approved-Closed 08/27/2010	SLA-HIAPP10	Application/ Enrollment Form	Application	Initial			Application.pdf
Approved-Closed 08/27/2010	SLA-HI10OOC	Outline of Coverage	Outline of Coverage	Initial			Generic OOC July 22.pdf

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

A Stock Life Insurance Company
HOME OFFICE: ONE MOODY PLAZA, GALVESTON, TEXAS 77550

HOSPITAL CONFINEMENT INSURANCE POLICY

This Policy is a contract of insurance. **READ IT CAREFULLY.**

We pay benefits in accordance with all the terms and conditions of this Policy.

IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR APPLICATION - You should read Your Application and all documents attached to Your Policy. **Omissions or misstatements in Your Application or any attached documents may cause Us to deny an otherwise valid claim or rescind coverage.** Carefully check all documents. You must advise Our Underwriting Department in writing within 10 days of Your receipt of this Policy if You determine that any information or medical history is incomplete, incorrect, or has changed since the date of Your Application.

Your Application and all attached documents are part of this Policy. We provide coverage described in this Policy on the basis that all of the answers to the questions and all the material information contained in the documents are correct and complete. No agent or employee, except an officer of the Company, has the authority to waive any of the requirements in the documents or waive any of the provisions of this Policy.

We do not provide coverage until Your Application has been approved and Your Initial Premium is paid. The Initial Premium pays for Your Initial Term of coverage. Your Initial Term of coverage begins at 12:01 A.M., local time, at Your residence on Your Effective Date. Coverage is continued in accordance with all of the provisions of this Policy.

30 DAY RIGHT TO EXAMINE THIS POLICY – You may return this Policy to Us for any reason within 30 days after You receive it. You may bring it in person or mail it to Us. At the time You return this Policy, coverage under this Policy is void from the beginning. We will refund any premium paid.

GUARANTEED RENEWABLE AT THE OPTION OF THE POLICYHOLDER – SUBJECT TO PREMIUM IN EFFECT AT THE TIME OF RENEWAL. You have the right to continue this Policy in force subject to the termination provisions and Your continued payment of premium in accordance with all the provisions of this Policy.

PREMIUMS ARE SUBJECT TO CHANGE - Please refer to the section titled **PREMIUMS**.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, You should review the guide *Medicare & You* available from the Company.

SECRETARY

PRESIDENT

THIS POLICY PROVIDES BENEFITS FOR EACH DAY A COVERED PERSON IS HOSPITAL CONFINED FOR MEDICALLY NECESSARY TREATMENT OF INJURY OR SICKNESS.

HOSPITAL CONFINEMENT INSURANCE POLICY

THIS POLICY PROVIDES BENEFITS FOR EACH DAY A COVERED PERSON IS HOSPITAL CONFINED FOR MEDICALLY NECESSARY TREATMENT OF INJURY OR SICKNESS.

POLICY SCHEDULE

BENEFIT	BENEFIT AMOUNT
AMBULANCE BENEFIT	50% of Daily Hospital Confinement Benefit
HOSPITAL ADMISSION BENEFIT	[$1-1,000] per Benefit Period
HOSPITAL CONFINEMENT BENEFIT	[$50-1000] per Day
MAXIMUM NUMBER OF DAYS	[365] Days
SAME DAY SURGERY FACILITY BENEFIT	Same as Hospital Confinement Benefit
REHABILITATION FACILITY CONFINEMENT	75% of Daily Hospital Confinement Benefit

POLICYHOLDER Information

Policy Number: [123-45-6789]
Policyholder Name: [John J. ANICO]
Date of Birth: [April 15, 1968]

Effective Date: [August 1, 2010]
Issue Age: [42]

COVERED PERSONS	RELATIONSHIP	AGE	DATE OF BIRTH
JJ ANICO	POLICYHOLDER	203	04/22/1807
GG ANICO	SPOUSE	24	04/16/1986

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PREMIUMS

Premiums are due on the first day of each term that follows the Initial Term. This is called the Premium Due Date. The required premium will depend on Your premium class. We determine the premium class on each Premium Due Date. We will NOT CHANGE Your premium prior to Your first Policy anniversary, unless coverage changes. After Your first Policy anniversary, We may change premiums anytime, and from time to time, that We decide to change rates for persons in Your class.

Changes will apply to premiums due on or after the effective date of the change. The new rates will apply on a class basis as determined by Us. We will give You 60 days notice before any premium change.

WAIVER OF PREMIUM – If You are continuously Hospital Confined for 30 days, We will waive the next monthly premium due. If You remain Hospital Confined as a continuation of the 30 day confinement that caused the first waiver of premium, We will waive subsequent monthly premiums while You remain continuously Hospital Confined on each subsequent monthly premium due date. During any premium waiver period, premium modes other than monthly will be changed to monthly during the continuation of premium waiver.

DEFINITIONS

AMBULANCE means a motor vehicle, helicopter, or fixed wing aircraft specially equipped to transport Sick and Injured people. Transportation by a common carrier is not covered.

BENEFIT PERIOD is a period of time which begins with your first full day in a hospital. It ends when you have not been in a hospital or nursing facility for [60] consecutive days.

CALENDAR YEAR means the twelve-month period that begins January 1 and ends December 31, each year.

CLOSE RELATIVE means anyone related to You by blood, marriage, or adoption; or a court appointed representative.

COMPLICATIONS OF PREGNANCY means either of these two general types of conditions:

1. **TYPE I CONDITIONS:** The pregnancy does not end. The cause of the complication is distinct from the pregnancy. Examples include acute nephritis, nephrosis, and cardiac decompensation. There may be other similar conditions as well.

2. **TYPE II CONDITIONS**: The pregnancy ends. Any of the following may occur: delivery by Medically Necessary Cesarean section, ending of ectopic pregnancy, or spontaneous ending of pregnancy that takes place when a live birth is not possible.

THE FOLLOWING CONDITIONS ARE NOT COMPLICATIONS OF PREGNANCY: false labor; pre-term or premature labor; occasional spotting; prescribed rest while pregnant; morning sickness; hyperemesis gravidarum; or pre-eclampsia. There may be other conditions that relate to a difficult pregnancy that a Doctor can manage. We will not consider such a condition as a Complication of Pregnancy.

COVERED PERSON means each person named as a Covered Person on the Policy Schedule whose coverage under this Policy has not terminated.

DOCTOR means a person, other than You or a Close Relative, who is duly licensed to provide the type of medical treatment for which benefits are provided under this Policy, and acting within the scope of that license.

EFFECTIVE DATE means the date, shown in Your Policy Schedule, when coverage begins for the Covered Persons originally covered under this Policy. We use the Effective Date to determine the anniversary dates of coverage under this Policy. It also refers, separately, to the date We add a Covered Person to this Policy or when any change in coverage occurs.

HOSPITAL means an institution that:
(1) operates as a Hospital pursuant to law;
(2) operates primarily for the reception, care and treatment of sick or injured persons as Inpatients;
(3) provides 24-hour nursing service by Registered Nurses on duty or on call;
(4) has a staff of one or more Physicians available at all times;
(5) provides organized facilities for diagnosis, treatment and surgery either on its premises or in facilities available to it on a pre-arranged basis.

Hospital **does NOT include** the following whether free-standing or a section of another facility: (a) convalescent homes or convalescent, rest or nursing facilities; (b) facilities primarily affording custodial or educational care; (c) facilities primarily affording rehabilitative care; or (d) facilities for the aged, drug addicts or alcoholics.

HOSPITAL CONFINED means that a Covered Person is admitted to a Hospital as an overnight resident bed patient, including confinement in an Intensive Care Unit. This term does not relate to a Covered Person's treatment in a Same Day Surgery facility, Emergency room, an observation room, or confinement in a Rehabilitation Facility.

HOSPITAL STAY means the period of time, measured in days from the date of Hospital Admission to the date of discharge, a Covered Person is Hospital Confined, including confinement in an Intensive Care Unit. For purposes of calculating benefits, successive Hospital Stays for the same or related causes, separated by 60 days or less, during which no Hospital Confinement occurs, will be treated as a single Hospital Stay.

INJURY (Injured) means accidental bodily injury sustained by the Covered Person which is the direct cause of loss, independent of disease, bodily infirmity, or any other cause which occurs while coverage under this Policy is in force.

INTENSIVE CARE UNIT (INCLUDING CORONARY CARE UNIT OR NEONATAL INTENSIVE CARE UNIT) means that part of a Hospital specifically designed as an intensive care unit that is permanently equipped and staffed to provide more extensive care for critically ill or Injured patients than is available in other Hospital rooms or wards. Services provided include close observation by trained and qualified personnel whose duties are primarily confined to the part of the Hospital for which an additional charge is made.

LIMITING AGE for Your children is age 26.

MEDICALLY NECESSARY means that, based on generally accepted current medical practice, a service or supply is necessary and appropriate for the diagnosis or treatment of Injury or Sickness. We do not consider a service or supply as Medically Necessary if:
1. It is provided only as a convenience to the Covered Person or provider;
2. It is not appropriate treatment for the Covered Person's diagnosis or symptoms;
3. It exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment; or
4. It is Experimental or Investigational Medicine.

The fact that a Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

MENTAL DISORDER means a disease or disorder, regardless of its cause, that affects the mind or behavior. Categories of mental disorders include mood disorders, anxiety disorders, psychotic disorders, eating disorders, developmental disorders, personality disorders, and other generally accepted disorders of a similar type.

POLICYHOLDER means You, the Applicant named in the attached Application, any successor thereof, or any person named to assume ownership privileges under this Policy after the original Policyholder's death. Such person, regardless of title, has exclusive ownership privileges under this Policy. These privileges include, but are not limited to, his/her right to change coverage under this Policy for themselves or any Covered Person.

PRE-EXISTING CONDITION means a condition not otherwise excluded by name or specific description: (1) for which medical advice, testing, care, treatment or medication was given or was recommended by, or received from, a Doctor within 6 months before the Effective Date; or (2) that would have caused a reasonably prudent person to seek medical diagnosis or treatment within 6 months before the Effective Date. The Company does not cover Pre-Existing Conditions for the first 6 months of coverage.

REHABILITATION FACILITY means a specialized section of a Hospital or a properly licensed free standing facility that provides services under the direction of a Doctor that are rehabilitative or restorative; and are consistent with the standards of practice for rehabilitative medicine.

SAME DAY SURGERY FACILITY means a licensed medical facility or a part of a Hospital:

1. With an organized staff of Doctors;
2. That is permanently equipped and operated primarily for the purpose of performing surgical procedures;
3. That does not provide accommodations for overnight stays; and
4. That provides continuous Doctor services and nursing services whenever a patient is in the facility.

The term "Same Day Surgery Facility" does not include a:

1. Hospital Emergency room;
2. Trauma center; or
3. Doctor's office or Clinic.

SICKNESS means a Covered Person's illness, disease, or condition that begins after the Effective Date and while such Covered Person has coverage under this Policy. Sickness also includes an illness, disease or condition that begins before the Effective Date if it is shown on the Covered Person's Application and We have not excluded it from coverage by name or specific description. Sickness includes any complications or recurrences that relate to such Sickness while this Policy's coverage in effect for the Covered Person.

US, WE, OUR or THE COMPANY means Standard Life and Accident Insurance Company (SLAICO).

YOU or YOUR means the Applicant, named in the attached Application.

BENEFIT

In order for the Company to pay any benefit, described below, the following conditions must be met:
1. The described benefit service must begin after the Covered Person's Effective Date;
2. The described benefit service must be for the Medically Necessary treatment of a Covered Person's Injury or Sickness; and
3. The described benefit service must begin and continue while the Covered Person's coverage remains in effect under this Policy.

AMBULANCE BENEFIT – If a Covered Person requires the use of a ground or air ambulance for transportation to or from the Hospital to which the Covered Person is or was Hospital Confined, We will pay the Benefit Amount for this benefit shown in Your Policy Schedule for each ambulance trip. Benefits are also payable under this provision when the Covered Person is transported directly from a Hospital to a Rehabilitation Facility.

HOSPITAL ADMISSION BENEFIT – If a Covered Person is admitted to a Hospital and is Hospital Confined for at least one day, We will pay the Benefit Amount for this benefit shown in Your Policy Schedule. This benefit is paid in addition to any other benefits otherwise payable under the Policy. This benefit is only payable for one Hospital admission per Benefit Period for each Covered Person.

HOSPITAL CONFINEMENT BENEFIT - The Company will pay the benefit amount for this benefit shown in the Policy Schedule for each day a Covered Person is Hospital Confined, up to the Maximum Number of Days for any one Hospital Stay shown on Your Policy Schedule. The Hospital Confinement Benefit will not be paid for any day or part of a day for which the Intensive Care Unit Benefit is paid.

INTENSIVE CARE UNIT BENEFIT - The Company will pay [2] times the Hospital Confinement Benefit amount shown in Your Policy Schedule when a Covered Person is confined in an Intensive Care Unit up to a maximum of [30] days for any one Hospital Stay. The Intensive Care Unit Benefit will not be paid for any day or part of a day for which the **Hospital Confinement Benefit** is paid.

SAME DAY SURGERY FACILITY BENEFIT - If a Covered Person requires the use of a Same Day Surgery Facility, We will pay the Benefit Amount for this benefit shown in Your Policy Schedule for each day the Covered Person uses such facility

REHABILITATION FACILITY CONFINEMENT - If a Covered Person is admitted to a Rehabilitation Facility immediately following a covered Hospital Confinement of at least one day, We will pay the Benefit Amount for this benefit shown in Your Policy Schedule for each day they remain in a Rehabilitation Facility, up to 15 days per Calendar year.

EXCEPTIONS

THIS POLICY DOES NOT PROVIDE BENEFITS FOR LOSS RESULTING FROM ANY OF THE FOLLOWING EXCEPTED EVENTS.

1. Injury or Sickness that results from war or an act of war, whether war is declared or not.

2. Pregnancy and childbirth, except for Complications of Pregnancy.

3. Mental Disorders.

4. Cosmetic surgery or reconstructive surgery, including breast reduction and surgery to repair, replace, or remove breast implants; however, this Exception does not apply when surgery is required:

   a) To correct damage for a covered Injury or Sickness;
   b) To repair a birth defect of a child born to You and continuously covered under this Policy from its birth; or
   c) For reconstructive surgery following a covered mastectomy.

5. Dental Treatment, unless due to Injury to a Covered Person's natural teeth.

6. A Pre-Existing Condition as defined in this Policy.

7. Any attempt at suicide, while sane or insane.

8. An intentionally self-inflicted Injury, while sane or insane.

9. A Covered Person's commission of or attempt to commit a felony, an illegal act, or being engaged in an illegal occupation.

10. A Covered Person being intoxicated, unless such intoxication is the result of a prescription drug taken as prescribed by a Doctor.

11. A Covered Person with a blood alcohol concentration equal to or in excess of .08 gms/dl operating any motor vehicle, including any off-road vehicle; or watercraft.

12. Weight reduction or treatment of obesity, including exogenous, endogenous, or morbid obesity; .

13. Treatment provided outside the United States of America, its possessions and territories.

14. Routine newborn care.

15. Any charges for or relating to: artificial insemination; in-vitro fertilization or any other diagnosis or treatment for the control, promotion, or enhancement of fertility; treatment for impotency; sterilization or reversal of prior sterilization; abortion, unless the life of the mother would be endangered if the fetus were carried to term; or therapeutic abortion.

16. Treatment of alcoholism or drug use.

AUTOMATIC COVERAGE OF NEWBORN AND ADOPTED CHILDREN

A child born to or adopted by You will become a Covered Person under this Policy.

Newborns: Coverage for newborn children is free for the fist 90 days from the date of birth.

Adopted Children: Coverage for adopted children is free for the first 60 days of the filing of a petition for adoption if You apply for coverage within 60 days after the filing of the petition for adoption. The coverage is free for the first 60 days from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the minor.

In order to continue coverage for a newborn or adopted child, You must do the following:

1. Send Us notice of the child within the 90 days after the date of the child's birth or before the premium due date, whichever is later (or, in the case of an adopted child, within the 60 days after the filing of the petition for adoption or birth of child); and
2. Send Us the additional premium for the child within 90 days of the child's date of birth or within 60 days of the date of petition for adoption or birth of the child.

As long as You pay the extra premium, the child will remain a Covered Person, subject to the Termination of Coverage and Loss of Coverage Eligibility provisions of this Policy. Coverage for a child that is placed with You for adoption will continue in accordance with the Termination of Coverage and Loss of Coverage Eligibility provisions, unless the placement is disrupted prior to legal adoption and the child is removed from placement.

We do not require an application for the child unless You have notified Us of the child later than the timeframe as required above.

TERMINATION OF COVERAGE

We can terminate coverage under this Policy as of any premium due date under any of the following conditions:

1. You have failed to pay premiums in accordance with the terms of this Policy, or We have not received timely premium payments;
2. You or a Covered Person has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in applying for coverage or under the terms of this Policy, subject to the paragraph titled **MISSTATEMENTS IN THE APPLICATION** under General Provisions; or
3. A Covered Person ceases to be eligible for continued coverage under this Policy as described in the section titled **LOSS OF ELIGIBILITY**.

LOSS OF ELIGIBILITY

Eligibility for continuation of coverage under this Policy by a Covered Person ends on the date of the month that coincides with the date of the month shown on the Policy Schedule and occurs on such date next following the date of the event that causes such termination.

RULES FOR ALL COVERED PERSONS - Coverage will end:

1. If this Policy is terminated in accordance with the section titled **TERMINATION OF COVERAGE**; or
2. If You fail to pay the required premium within the Grace Period.

RULES FOR ADULT COVERED PERSONS - Coverage will end:

1. For Your spouse if there is a divorce;
2. If a mentally or physically disabled Covered Person marries or becomes capable of self-support; or
3. If Your spouse is not a Covered Person at the time of his/her death, We will end coverage for all Covered Persons.

If You are married and die and Your spouse is a Covered Person, Your spouse will become the Policyholder.

RULES FOR CHILD COVERED PERSONS - Coverage will end for a child when:

1. The child is no longer a dependent of Yours;
2. The child gets married;
3. The child attains the Limiting Age, except for the extension allowed by the section titled **EXTENSION OF COVERAGE FOR SOME CHILDREN**; or
4. Neither You nor Your spouse remains covered under this Policy.

PREMIUM – We will adjust premiums if required under Our rules as of the date coverage ends for a Covered Person. This will occur on a date consistent with the date coverage ends, as described above.

EXTENSION OF COVERAGE FOR SOME CHILDREN

When a dependent child who is a Covered Person has reached the Limiting Age, coverage may continue if the child is, and remains, incapable of self-sustaining employment, by reason of mental or physical handicap, and is chiefly dependent upon You for support and maintenance. The child will continue as a Covered Person if, in response to Our inquiry, You submit written proof of the child's incapacity and pay the premium for the child. The premium will be on the same basis as that for an adult of like age and sex. Extension of coverage will not continue for any child named in the Enrollment Application whose disabling condition existed prior to the Effective Date of such child's coverage and was not disclosed in the Enrollment Application.

CONVERSION PRIVILEGE

If coverage under this Policy has been terminated, Covered Persons may be entitled to have a conversion policy issued by SLAICO that provides coverage similar to this Policy, without evidence of insurability, subject to the following terms and conditions.

A conversion policy is not available to a Covered Person if termination of his insurance under this Policy occurs:

1. Because he failed to make timely payment of any required premium; or
2. For any other reason, and he had not been continuously covered under this Policy, and for similar benefits under any policy which it replaced, during the entire three (3) months period ending with such termination; or
3. Because this Policy terminated and the insurance was replaced by similar coverage under another policy within thirty-one (31) days of the date of termination; and
4. Written application and the first premium payment for the conversion policy shall be made to SLAICO not later than thirty-one (31) days after such termination.

The premium for the conversion policy shall be determined in accordance with SLAICO's table of premium rates applicable to the age and class of risk of each person to be covered under that policy and to the type and amount of insurance provided.

The conversion policy shall cover the Covered Persons on the date his/her coverage terminates under this Policy. At the option of SLAICO, a separate conversion policy may be issued to cover any dependent.

The conversion policy will not exclude, as a Pre-Existing Condition, any condition covered by this Policy; provided, however, that the conversion policy may provide for a reduction of its benefits by the amount of any such benefits payable under this Policy after the individual's insurance terminates.

GENERAL PROVISIONS

ENTIRE CONTRACT -- The Entire Contract will consist of:

1. This Policy;
2. Your Application and attached papers; and
3. Any riders, endorsements or amendments issued with or added to this Policy.

We will deem all the statements provided in any attached Application and attached supplements, except fraudulent statements, as representations and not warranties.

TIME LIMIT ON CERTAIN DEFENSES --

1. MISSTATEMENTS IN THE ENROLLMENT APPLICATION --
After 1 year from the date a Covered Person becomes insured under this Policy, We may only use fraudulent misstatements in the Enrollment Application to void coverage under this Policy or to deny any claim for loss incurred after such 1 year period.

2. PRE-EXISTING CONDITIONS --
No claim for loss incurred after 6 months from the Effective Date will be reduced or denied because a Sickness or Injury, not excluded by name or specific description before the date of loss, existed 6 months before the Effective Date.

REINSTATEMENT -- Coverage terminates if You do not pay a periodic premium payment before the end of the Grace Period. Our later acceptance of premium, (or one of our authorized agent's acceptance of premium) without requiring an application for reinstatement, reinstates coverage under this Policy.

We will require an application for reinstatement. We will subject all representations made in this application to all of the provisions of this Policy, including TIME LIMIT ON CERTAIN DEFENSES. If We approve the application for reinstatement, We will reinstate coverage as of the approval date of the reinstatement Enrollment Application. If We do not approve the reinstatement and do not notify You in writing of the disapproval, We must reinstate coverage. The reinstatement will take place on the 45th day following the date of Our receipt of the application for reinstatement.

The reinstated plan only covers loss resulting from:

1. Injury that occurs after reinstatement; and
2. Sickness that begins ten days or more after the Covered Person's date of reinstatement.

In all other respects, the Covered Person's rights and Our rights will remain the same, except as stated in any application attached to the reinstated coverage.

We will apply any premiums that We accept for reinstatement to a period for which You have not paid premiums. We will not apply any premium to any period more than 60 days before the reinstatement date.

WE WILL NOT CONSIDER A REQUEST FOR REINSTATEMENT THAT YOU MAKE MORE THAN 180 DAYS AFTER YOUR COVERAGE UNDER THIS POLICY HAS TERMINATED.

GRACE PERIOD -- There is a 31 day grace period for the payment of any premium. If a renewal premium is not paid on or before its due date, it may be paid during the following 31 days. If We do not receive the payment during this Grace Period, We will terminate coverage. Termination will be effective as of the end of the period for which premium was paid.

NOTICE OF CLAIMS -- A claimant must give notice of claim within 30 days after a covered loss starts or as soon as reasonably possible. The claimant must give the notice to Us at Our Home Office in Galveston, Texas. The notice must include the claimant's name and his/her Policy Number.

CLAIM FORMS -- When We receive notice of claim, We will send the claimant forms for filing Proof of Loss. If We do not mail the claimant these forms within 15 days of Our receipt of his/her request, the claimant will have met the Proof of Loss requirement. However, the claimant must still give Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

PROOFS OF LOSS -- The claimant must give written Proof of Loss to the Home Office in Galveston, Texas within 90 days after such loss. If it was not reasonably possible for the claimant to give the Proof of Loss in the time required, We will not reduce or deny the claim as long as the claimant gives proof as soon as reasonably possible. In any event, the claimant must give proof no later than 1 year from the time specified, unless the claimant was legally incapacitated.

TIME FOR PAYMENT OF CLAIMS -- All benefits payable under this Policy will be paid upon Our receipt of Proof of Loss.

PAYMENT OF CLAIMS -- We will pay Policy benefits to You. If You have died, We will pay any unpaid benefits to Your estate. We may pay benefits up to [$1,000] to someone related to You by blood or marriage or to any other person We deem entitled to the benefits if:

1. A court has deemed You incompetent; or
2. You have died and Your estate is not able to execute a valid release.

NO ASSUMPTION OF LIABILITY -- Our payment of any claim does not mean We have assumed liability for future payments for the same condition or any related condition once:

1. We determine that no covered loss occurred; or
2. We determine that Our payment was erroneous or inappropriate.

PHYSICAL EXAMINATIONS -- We have the right to have any Covered Person examined as often as reasonably required while a claim is pending for that person. We will pay for the requested physical examination.

LEGAL ACTIONS -- No legal action may be brought to recover on this Policy within 60 days after a claimant gives written Proof of Loss. No legal action may be brought after 3 years from the time this Policy requires written proof of loss.

LIMITATION OF LIABILITY -- You agree that Our maximum liability under this Policy and related matters is limited to:

1. Policy benefits otherwise payable;
2. Your reasonable attorneys fees, if any; and
3. Any statutory penalties that may be imposed.

MISSTATEMENTS OF AGE -- If a Covered Person has misstated his age, the benefits will be those the premium paid would have purchased if the correct age had been disclosed. However, if on the Effective Date, We would not have granted coverage because of the Covered Person's correct age, We are only liable for the return of any premiums paid on account of such person.

REFUND OF PREMIUM AT DEATH – If the Policy is in force when You die, coverage will end and the pro rata unearned portion of any premium paid will be refunded. Unearned premiums will be paid in a lump sum no later than thirty (30) days after We receive proof of Your death.

CONFORMITY WITH STATE STATUTES -- Any provision of this Policy which, on the Effective Date, is in conflict with the laws of the state in which You reside is amended to conform to the minimum requirements of the laws of such state.

ILLEGAL OCCUPATION -- We will not be liable for any loss that results from a Covered Person engaging in an illegal occupation or committing or attempting to commit a felony.

HOSPITAL CONFINEMENT INSURANCE POLICY

THIS POLICY PROVIDES BENEFITS FOR EACH DAY A COVERED PERSON IS HOSPITAL CONFINED FOR MEDICALLY NECESSARY TREATMENT OF INJURY OR SICKNESS.

POLICY SCHEDULE

BENEFIT	BENEFIT AMOUNT
AMBULANCE BENEFIT	50% of Daily Hospital Confinement Benefit
HOSPITAL ADMISSION BENEFIT	[$1-1,000] per Benefit Period
HOSPITAL CONFINEMENT BENEFIT	[$50-1000] per Day
MAXIMUM NUMBER OF DAYS	[365] Days
SAME DAY SURGERY FACILITY BENEFIT	Same as Hospital Confinement Benefit
REHABILITATION FACILITY CONFINEMENT	75% of Daily Hospital Confinement Benefit

POLICYHOLDER Information

Policy Number: [123-45-6789]
Policyholder Name: [John J. ANICO]
Date of Birth: [April 15, 1968]

Effective Date: [August 1, 2010]
Issue Age: [42]

COVERED PERSONS	RELATIONSHIP	AGE	DATE OF BIRTH
JJ ANICO	POLICYHOLDER	42	04/15/1968
GG ANICO	SPOUSE	24	04/16/1986

AUTHORIZATION TO MY BANK

PREAUTHORIZED CHECK AUTHORIZATION

Attach Voided Check or Deposit Ticket Here and Sign Authorization

❑ Checking ❑ Savings

Bank Information

_____

Name

_____

City State Zip

We will not draft from your account until underwriting approves your application.

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of Standard Life and Accident Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such checks. I further agree should any such checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. If this application is taken over the phone, I agree that my electronic signature serves as my original signature.

_____

Date Signed

✓ _____

Signature (as it appears on bank records)

Complete if no personalized deposit ticket is available.

Account Number _____

Routing Number _____

SLA-HIAPP10

HOSPITAL INDEMNITY APPLICATION

Standard Life

A Member of the American National Family of Companies

Standard Life and Accident Insurance Company

Mailing Address:
P.O. Box 696870, San Antonio, TX 78269

888.350.1488

Standard Life and Accident Insurance Company
Mailing Address: P.O. Box 696870 • San Antonio, TX 78269 • 888.350.1488

HOSPITAL INDEMNITY INSURANCE APPLICATION

Please Print — Use Black Ink ❑ New Policy ❑ Reinstatement

SECTION A

1. Please print the full name of all Proposed Insureds (Use additional sheet and attach if needed).

Last, First, Middle Initial	Social Security Number	Relationship	Sex M/F	Date of Birth Month, Day, Year	Age	Height (ft.-in.)	Weight (lbs.)
A.		Applicant					
B.		Spouse					
C.							
D.							

2. Home Address _____ City _____ State ____ Zip _____
Phone: Home (_____) _____ Email: _____

3. **PREMIUM DATA**

	Amount	Premium
Hospital Admission Benefit:	❑ $500 ❑ $1,000	$_____
Hospital Confinement Benefit:	$_____/Day	$_____
Total Billable Premium:		$_____

Mode: ❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ Monthly PAC
Method: ❑ Direct ❑ Salary Deduction
Franchise Name _____
Franchise Number _____

4. Has any Proposed Insured ever been declined, restricted, rated-up, or postponed for any kind of life or health insurance with this or any other company? ..... ❑ **Yes** ❑ **No**
If Yes, give details: _____

5. Does any Proposed Insured currently have more than one Medical Expense and/or Hospital Indemnity Policy with this or any other company? ..... ❑ **Yes** ❑ **No**
If Yes, please name company and give details in chart below:

Plan Type	Company	To Be Replaced?	Plan Type	Company	To Be Replaced?
		❑ **Yes** ❑ **No**			❑ **Yes** ❑ **No**
		❑ **Yes** ❑ **No**			❑ **Yes** ❑ **No**

SECTION B (Proposed Insured is not eligible for Hospital Indemnity insurance if any question in SECTION B is answered "Yes".)

6. Is any Proposed Insured or family member of the household an expectant mother or expectant father? ..... ❑ **Yes** ❑ **No**
7. Within the past 2 years, has any Proposed Insured had symptoms, treatment or been recommended to have treatment for: Addison's Disease, Alzhemier's, Internal Cancer, COPD, Connective Tissue Disorder, Chrohn's Disease, Cystic Fibrosis, Dementia, Insulin Dependent Diabetes, Emphysema, Heart Attack, Heart Disease, Heart Bypass, Heart Stents, Hepatitis, Cirrhosis of the Liver, Hodgkins, End Stage Renal Disease, Leukemia, Lupus, Multiple Sclerosis, Muscular Dystrophy, Organ Transplant (except corneal), Parkinson's, Paralysis, Peripheral Vascular Disease, Stroke, TIA or Amyotrophic Lateral Sclerosis (ALS)? ..... ❑ **Yes** ❑ **No**
8. Has any Proposed Insured been diagnosed by a physician, or tested positive or treated for HIV, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ..... ❑ **Yes** ❑ **No**
9. Has any Proposed Insured been advised to be admitted to a hospital, nursing home, clinic, or other institution for diagnosis or treatment or had surgery or medical tests recommended, but not yet performed? ..... ❑ **Yes** ❑ **No**

SECTION C

10. Has any Proposed Insured had symptoms of, or been treated for any of the following within the past 2 years:
    a. High or low blood pressure, elevated cholesterol, chest pain, coronary artery disease, circulatory disorder, or heart abnormality with or without surgery? ..... ❑ **Yes** ❑ **No**
    b. Disease or disorder of the lungs or respiratory system, reproductive organs, gallbladder, urinary tract, digestive tract, intestines or colon, kidney, liver, or pancreas? ..... ❑ **Yes** ❑ **No**
    c. Disease or disorder of the bones, joints, spine, knees, or musculoskeletal system? ..... ❑ **Yes** ❑ **No**
    d. Disease of the nervous system to include organic brain syndrome or other neurodegenerative disorders? ..... ❑ **Yes** ❑ **No**
    e. Mental or emotional disorder, alcoholism, chemical use, drug use (other than prescribed), or abuse of prescription drugs? ..... ❑ **Yes** ❑ **No**
    f. Hernia, hemorrhoids, cataracts, endometriosis, uterine fibroids, prostate disorder, gallstones, or kidney stones? ..... ❑ **Yes** ❑ **No**
    g. Disease or disorder of the blood, spleen, bone marrow, or disorder of the immune system? ..... ❑ **Yes** ❑ **No**
11. Has any Proposed Insured received medical counseling, been treated in an emergency room or urgent care center, been admitted to any hospital, nursing home, clinic, or other institution for diagnosis or treatment within the past 2 years? ..... ❑ **Yes** ❑ **No**
12. Has any Proposed Insured taken a medication recommended or prescribed by a Physician in the past 12 months? ..... ❑ **Yes** ❑ **No**

Give full details below of all "Yes" answers to questions 10-12, include all dates, names and addresses of hospitals and all Physicians, nature of the condition or impairment, the treatment or advice given and if released from the treatment (use additional sheet and attach if needed).

Question Number	Proposed Insured	Date of Treatment From	To	Reason for Condition Diagnosis, Injury, etc.	Degree of Recovery	Name/Address of Attending Physicians (Street, City, State)

SECTION D

ATTENTION — After the application has been completed, and before you sign it, reread it carefully to be certain that all information has been properly recorded.

ACKNOWLEDGMENT — If eligible for Medicare, I have received *Medicare and You* and the Important Notice to Persons on Medicare.

FRAUD WARNING — Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, submits an application for insurance or makes a claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information may be guilty of a felony.

APPLICATION DECLARATION AND AGREEMENT — Each of the undersigned has completed this application and represents that the answers and statements in Sections A, B and C on this application are true, complete, and correctly recorded; and agree they will be used to determine each Proposed Insured's eligibility for coverage under the health insurance plan requested hereby. I understand and agree that: **1.** all statements and answers in this application and in any supplements or amendments to it are complete and true; **2.** any incorrect or incomplete information on this application may result in loss of coverage or claim denial; **3.** no insurance shall take effect unless a policy is issued (or this application is made to change or reinstate an existing policy, unless the change is approved) and actually delivered to the Applicant and the first full premium paid during the lifetime and good health of all Proposed Insureds. I will notify and provide the Company with any evidence required by it to determine my future eligibility under the policy issued. If this application is taken over the phone, I agree that my electronic signature serves as my original signature.

I understand and agree that: 1. eligibility for the Plan does not constitute initial coverage under the Plan; and **2.** initial coverage under the Plan is subject to the Company's criteria.

Date	Dated at City, State	Applicant's Signature	Spouse's Signature (if coverage is requested for spouse)

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any: physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policyholder, employer, benefit plan administrator, the Medical Information Bureau, the Department of Motor Vehicle Registration, and paramedical facility to provide to STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on STANDARD LIFE AND ACCIDENT INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care or treatment sought by or provided to me and/or any other Proposed Insured for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug, alcohol or tobacco usage of the Proposed Insured. It is understood that STANDARD LIFE AND ACCIDENT INSURANCE COMPANY underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it, resulting in loss of protection by federal regulations.

I understand that: **1.** such information will be used by STANDARD LIFE AND ACCIDENT INSURANCE COMPANY for underwriting and insurability determinations; **2.** I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain health insurance coverage; **3.** a picture copy or photocopy of this authorization shall be as valid as the original; and **4.** I, or my authorized representative, am entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of STANDARD LIFE AND ACCIDENT INSURANCE COMPANY, P.O. Box 1991, Galveston, Texas 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.* If this application is taken over the phone, I agree that my electronic signature serves as my original signature.

Signed at _____
City and State

_____
Applicant's Signature

_____
Date

_____
Spouse's Signature (if coverage is requested for spouse)

_____
Witness

_____
Personal Representative designated by signature above is hereby authorized to execute this instrument based on: (circle one) power of attorney, guardian-in-fact, guardian, payee representative or other _____ .

AGENT STATEMENT

I have verified the Applicant's identity through a U.S. federal or state government-issued I.D. such as driver's license, government-issued I.D., passport, visa, etc. ... ❑ **Yes** ❑ **No**

I have inquired about and have personal knowledge of the medical history of each Proposed Insured.

Agent's Name (please print) _____

Agent's Signature _____

Agent's Code _____

Phone ( ) _____

Fax ( ) _____

Email Address _____

❑ Cash collected with Application: $ _____

❑ No money collected. Initial premium is to be drafted.

Mail Policy to: ❑ Applicant ❑ Agent

Special Request: _____

Hospital Confinement Indemnity

OUTLINE OF COVERAGE

POLICY FORM SERIES SLA-HI 10

Standard Life and Accident Insurance Company

A Member of the American National Family of Companies

Mailing Address:

P.O. Box 696870

San Antonio, Texas 78269

Phone: 888.350.1488

(referred hereafter as “Standard Life”, “we”, “us”, “our” or “the Company”)

COVERAGE PROVIDED BY THE POLICY IS HOSPITAL CONFINEMENT INDEMNITY COVERAGE AND IT PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

1. Read your Policy carefully. This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and Standard Life. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

2. Hospital confinement indemnity coverage is designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.

3. **BENEFITS** **BENEFIT AMOUNT**

Ambulance Benefit	50% of Daily Hospital Confinement Benefit
Hospital Admission Benefit	[$1-1,000] per Benefit Period
Hospital Confinement Benefit	[$50-1,000] per Day
Intensive Care Benefit	2 times the Hospital Confinement Benefit up to 30 days per Hospital Stay
Maximum Number of Days	[365] Days
Same Day Surgery Facility Benefit	Same as Hospital Confinement Benefit
Rehabilitation Facility Confinement	75% of Daily Hospital Confinement Benefit

4. **EXCEPTIONS, LIMITATIONS AND REDUCTIONS**

A. EXCEPTIONS

THIS POLICY DOES NOT PROVIDE BENEFITS FOR LOSS RESULTING FROM ANY OF THE FOLLOWING EVENTS.

1. Injury or sickness that results from war or an act of war, whether war is declared or not.
2. Pregnancy and childbirth, except for Complications of Pregnancy.
3. Mental Disorders.
4. Cosmetic surgery or reconstructive surgery, including breast reduction and surgery to repair, replace, or remove breast implants; however, this exception does not apply when surgery is required:
    a. to correct damage for a covered injury or sickness;
    b. to repair a birth defect of a child born to you and continuously covered under this Policy from its birth; or
    c. for reconstructive surgery following a covered mastectomy.
5. Dental treatment, unless due to injury to a Covered Person's natural teeth.
6. A Pre-Existing Condition as defined in this Policy.
7. Any attempt at suicide, while sane or insane.
8. An intentionally self-inflicted injury, while sane or insane.
9. A Covered Person's commission of or attempt to commit a felony, an illegal act, or being engaged in an illegal occupation.
10. A Covered Person being intoxicated, unless such intoxication is the result of a prescription drug taken as prescribed by a doctor.
11. A Covered Person with a blood alcohol concentration equal to or in excess of .08 gms/dl operating any motor vehicle, including any off-road vehicle; or watercraft.
12. Weight reduction or treatment of obesity, including exogenous, endogenous, or morbid obesity.
13. Treatment provided outside the United States of America, its possessions and territories.
14. Routine newborn care.

15. Any charges for or relating to: artificial insemination; in-vitro fertilization or any other diagnosis or treatment for the control, promotion, or enhancement of fertility; treatment for impotency; sterilization or reversal of prior sterilization; abortion, unless the life of the mother would be endangered if the fetus were carried to term; or therapeutic abortion.

16. Treatment of alcoholism or drug use.

B. LIMITATIONS

1. Standard Life may reduce or deny a claim or void the policy until such policy has been in effect for one year, if you make an omission or misrepresentation of material fact in the application for the policy;

2. Standard Life may deny or void the policy at any time if you made a fraudulent material misstatement in the application for the policy.

5. **RENEWABILITY**

We can terminate coverage under this Policy as of any premium due date under any of the following conditions:

A. you have failed to pay premiums in accordance with the terms of this Policy, or we have not received timely premium payments;

B. you or a Covered Person has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in applying for coverage or under the terms of this Policy, subject to the paragraph titled **MISSTATEMENTS IN THE APPLICATION** under General Provisions; or

C. a Covered Person ceases to be eligible for continued coverage under this Policy as described in the section titled **LOSS OF ELIGIBILITY.**

Premiums are subject to change.

6. **Initial Premium:** $_____ As stated in section 5, premiums are subject to change.

Mode of Payment Selected: ❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ Monthly PAC

Initial Modal Premium: $_____

The Policy has a 31-day grace period.

This Outline is a brief description of the policy terms and provisions. Refer to the policy for further details.

SERFF Tracking Number:	*ANTX-126722485*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*46508*
Company Tracking Number:	*SLA-HI10(AR)*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*SLAICO HIP (AR)*		
Project Name/Number:	*/*		

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
Approved-Closed 08/27/2010	Rates	SLA-HI 10(AR)	New		Annual_Premium_Rates.pdf

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY
ONE MOODY PLAZA GALVESTON, TEXAS 77550

ANNUAL PREMIUM RATES FOR POLICY FORM SLA-HI 10

Base Plan

	Individual	Two Adults	One Parent Family	Two Parent Family
<39	168	241	301	374
40-49	230	353	397	520
50-59	325	525	425	625
60-64	454	758	521	825
65-69	602	1,029	665	1,093
70-74	771	1,335	834	1,398

Each Additional $250 of Initial Hospitalization benefit

	Individual	Two Adults	One Parent Family	Two Parent Family
<39	16	28	37	49
40-49	27	50	54	76
50-59	42	77	58	92
60-64	63	115	74	125
65-69	105	191	115	201
70-74	142	257	152	267

Each Additional Increment ($100 Daily Room Ben) of Base Plan Other than Initial Hospitalization

	Individual	Two Adults	One Parent Family	Two Parent Family
<39	59	107	151	199
40-49	97	176	212	291
50-59	163	294	231	363
60-64	250	452	295	498
65-69	317	574	361	617
70-74	413	748	457	791

Modal Factors

Monthly Direct	Annual x	0.1000
Monthly PAC	Annual x	0.0875
Quarterly	Annual x	0.2700
Semi-Annual	Annual x	0.5200

SERFF Tracking Number:	*ANTX-126722485*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*46508*
Company Tracking Number:	*SLA-HI10(AR)*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*SLAICO HIP (AR)*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	08/27/2010

Comments:

Attachment:

READ - slaico.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	08/27/2010

Comments:

Please see Forms Tab.

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	08/27/2010

Comments:

Please see Forms Tab.

		Item Status:	Status Date:
Satisfied - Item:	Arkansas Notice	Approved-Closed	08/27/2010

Comments:

Company intends to use previously approved Notice, attached.

Attachment:

AR-Imp-Information-Notice.pdf

		Item Status:	Status Date:
Satisfied - Item:	Third Party Authorization	Approved-Closed	08/27/2010

Comments:

Attachment:

SERFF Tracking Number:	*ANTX-126722485*	*State:*	*Arkansas*
Filing Company:	*Standard Life and Accident Insurance Company*	*State Tracking Number:*	*46508*
Company Tracking Number:	*SLA-HI10(AR)*		
TOI:	*H14I Individual Health - Hospital Indemnity*	*Sub-TOI:*	*H14I.000 Health - Hospital Indemnity*
Product Name:	*SLAICO HIP (AR)*		
Project Name/Number:	*/*		

AUTH TO FILE SLAICO.pdf

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY
ONE MOODY PLAZA
GALVESTON, TEXAS

READABILITY CERTIFICATION

We hereby certify that form(s) SLA-HI10(AR), et. al. has (have) achieved a Flesch scale readability score that meets the minimum reading ease score as required by the state of Arkansas.

James P. Stelling
Vice President , Health Compliance

Date: August 15, 2010

IMPORTANT INFORMATION FOR
ARKANSAS POLICYOWNERS

If you have questions about your policy or a claim you have filed, please contact your insurance company or your agent:

Standard Life and Accident Insurance Company
C/O Customer Service Department
P.O. Box 1820
Galveston, Texas 77553-1820

Telephone: 1-888-350-1488
1-409-763-4661

Agent_____
Address_____
_____
Telephone_____

If you are unable to resolve a problem with your insurance company or your agent, you may contact the Arkansas Department of Insurance:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1804

Telephone: 1-800-852-5494
1-501-371-2640
E-Mail: Insurance@mail.state.ar.us
Web Site: www.state.ar.us/insurance

CCN-AR3

A MEMBER OF THE AMERICAN NATIONAL FAMILY OF COMPANIES

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

One Moody Plaza, Galveston, Texas 77550-7999

September 30, 2004

Texas Department of Insurance
Life/Health Division
Filings Intake Mail Code 106-1E
333 Guadalupe
Austin, TX 78701

Re: Letter of Authorization

Dear Sir or Madam:

This letter authorizes Patty Clavette, an independent contractor, to submit health forms on behalf of the Company.

Sincerely,

William H. Watson III
Vice President

SERFF Tracking Number:	*ANTX-126722485*	*State:*	*Arkansas*
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Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
08/15/2010	Form	Hospital Confinement Policy	08/23/2010	Policy_AR_Aug 15 2010.pdf (Superceded)

STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

A Stock Life Insurance Company
HOME OFFICE: ONE MOODY PLAZA, GALVESTON, TEXAS 77550

HOSPITAL CONFINEMENT INSURANCE POLICY

This Policy is a contract of insurance. **READ IT CAREFULLY.**

We pay benefits in accordance with all the terms and conditions of this Policy.

IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR APPLICATION - You should read Your Application and all documents attached to Your Policy. **Omissions or misstatements in Your Application or any attached documents may cause Us to deny an otherwise valid claim or rescind coverage.** Carefully check all documents. You must advise Our Underwriting Department in writing within 10 days of Your receipt of this Policy if You determine that any information or medical history is incomplete, incorrect, or has changed since the date of Your Application.

Your Application and all attached documents are part of this Policy. We provide coverage described in this Policy on the basis that all of the answers to the questions and all the material information contained in the documents are correct and complete. No agent or employee, except an officer of the Company, has the authority to waive any of the requirements in the documents or waive any of the provisions of this Policy.

We do not provide coverage until Your Application has been approved and Your Initial Premium is paid. The Initial Premium pays for Your Initial Term of coverage. Your Initial Term of coverage begins at 12:01 A.M., local time, at Your residence on Your Effective Date. Coverage is continued in accordance with all of the provisions of this Policy.

30 DAY RIGHT TO EXAMINE THIS POLICY – You may return this Policy to Us for any reason within 30 days after You receive it. You may bring it in person or mail it to Us. At the time You return this Policy, coverage under this Policy is void from the beginning. We will refund any premium paid.

GUARANTEED RENEWABLE AT THE OPTION OF THE POLICYHOLDER – SUBJECT TO PREMIUM IN EFFECT AT THE TIME OF RENEWAL. You have the right to continue this Policy in force subject to the termination provisions and Your continued payment of premium in accordance with all the provisions of this Policy.

PREMIUMS ARE SUBJECT TO CHANGE - Please refer to the section titled **PREMIUMS**.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, You should review the guide *Medicare & You* available from the Company.

SECRETARY

PRESIDENT

THIS POLICY PROVIDES BENEFITS FOR EACH DAY A COVERED PERSON IS HOSPITAL CONFINED FOR MEDICALLY NECESSARY TREATMENT OF INJURY OR SICKNESS.

HOSPITAL CONFINEMENT INSURANCE POLICY

THIS POLICY PROVIDES BENEFITS FOR EACH DAY A COVERED PERSON IS HOSPITAL CONFINED FOR MEDICALLY NECESSARY TREATMENT OF INJURY OR SICKNESS.

POLICY SCHEDULE

BENEFIT	BENEFIT AMOUNT
AMBULANCE BENEFIT	50% of Daily Hospital Confinement Benefit
HOSPITAL ADMISSION BENEFIT	[$1-1,000] per Benefit Period
HOSPITAL CONFINEMENT BENEFIT	[$50-1000] per Day
MAXIMUM NUMBER OF DAYS	[365] Days
SAME DAY SURGERY FACILITY BENEFIT	Same as Hospital Confinement Benefit
REHABILITATION FACILITY CONFINEMENT	75% of Daily Hospital Confinement Benefit

POLICYHOLDER Information

Policy Number: [123-45-6789]
Policyholder Name: [John J. ANICO]
Date of Birth: [April 15, 1968]

Effective Date: [August 1, 2010]
Issue Age: [42]

COVERED PERSONS	RELATIONSHIP	AGE	DATE OF BIRTH
JJ ANICO	POLICYHOLDER	203	04/22/1807
GG ANICO	SPOUSE	24	04/16/1986

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PREMIUMS

Premiums are due on the first day of each term that follows the Initial Term. This is called the Premium Due Date. The required premium will depend on Your premium class. We determine the premium class on each Premium Due Date. We will NOT CHANGE Your premium prior to Your first Policy anniversary, unless coverage changes. After Your first Policy anniversary, We may change premiums anytime, and from time to time, that We decide to change rates for persons in Your class.

Changes will apply to premiums due on or after the effective date of the change. The new rates will apply on a class basis as determined by Us. We will give You 60 days notice before any premium change.

WAIVER OF PREMIUM – If You are continuously Hospital Confined for 30 days, We will waive the next monthly premium due. If You remain Hospital Confined as a continuation of the 30 day confinement that caused the first waiver of premium, We will waive subsequent monthly premiums while You remain continuously Hospital Confined on each subsequent monthly premium due date. During any premium waiver period, premium modes other than monthly will be changed to monthly during the continuation of premium waiver.

DEFINITIONS

AMBULANCE means a motor vehicle, helicopter, or fixed wing aircraft specially equipped to transport Sick and Injured people. Transportation by a common carrier is not covered.

BENEFIT PERIOD is a period of time which begins with your first full day in a hospital. It ends when you have not been in a hospital or nursing facility for [60] consecutive days.

CALENDAR YEAR means the twelve-month period that begins January 1 and ends December 31, each year.

CLOSE RELATIVE means anyone related to You by blood, marriage, or adoption; or a court appointed representative.

COMPLICATIONS OF PREGNANCY means either of these two general types of conditions:

1. **TYPE I CONDITIONS:** The pregnancy does not end. The cause of the complication is distinct from the pregnancy. Examples include acute nephritis, nephrosis, and cardiac decompensation. There may be other similar conditions as well.

2. **TYPE II CONDITIONS**: The pregnancy ends. Any of the following may occur: delivery by Medically Necessary Cesarean section, ending of ectopic pregnancy, or spontaneous ending of pregnancy that takes place when a live birth is not possible.

THE FOLLOWING CONDITIONS ARE NOT COMPLICATIONS OF PREGNANCY: false labor; pre-term or premature labor; occasional spotting; prescribed rest while pregnant; morning sickness; hyperemesis gravidarum; or pre-eclampsia. There may be other conditions that relate to a difficult pregnancy that a Doctor can manage. We will not consider such a condition as a Complication of Pregnancy.

COVERED PERSON means each person named as a Covered Person on the Policy Schedule whose coverage under this Policy has not terminated.

DOCTOR means a person, other than You or a Close Relative, who is duly licensed to provide the type of medical treatment for which benefits are provided under this Policy, and acting within the scope of that license.

EFFECTIVE DATE means the date, shown in Your Policy Schedule, when coverage begins for the Covered Persons originally covered under this Policy. We use the Effective Date to determine the anniversary dates of coverage under this Policy. It also refers, separately, to the date We add a Covered Person to this Policy or when any change in coverage occurs.

HOSPITAL means an institution that:
(1) operates as a Hospital pursuant to law;
(2) operates primarily for the reception, care and treatment of sick or injured persons as Inpatients;
(3) provides 24-hour nursing service by Registered Nurses on duty or on call;
(4) has a staff of one or more Physicians available at all times;
(5) provides organized facilities for diagnosis, treatment and surgery either on its premises or in facilities available to it on a pre-arranged basis.

Hospital **does NOT include** the following whether free-standing or a section of another facility: (a) convalescent homes or convalescent, rest or nursing facilities; (b) facilities primarily affording custodial or educational care; (c) facilities primarily affording rehabilitative care; or (d) facilities for the aged, drug addicts or alcoholics.

HOSPITAL CONFINED means that a Covered Person is admitted to a Hospital as an overnight resident bed patient, including confinement in an Intensive Care Unit. This term does not relate to a Covered Person's treatment in a Same Day Surgery facility, Emergency room, an observation room, or confinement in a Rehabilitation Facility.

HOSPITAL STAY means the period of time, measured in days from the date of Hospital Admission to the date of discharge, a Covered Person is Hospital Confined, including confinement in an Intensive Care Unit. For purposes of calculating benefits, successive Hospital Stays for the same or related causes, separated by 60 days or less, during which no Hospital Confinement occurs, will be treated as a single Hospital Stay.

INJURY (Injured) means accidental bodily injury sustained by the Covered Person which is the direct cause of loss, independent of disease, bodily infirmity, or any other cause which occurs while coverage under this Policy is in force.

INTENSIVE CARE UNIT (INCLUDING CORONARY CARE UNIT OR NEONATAL INTENSIVE CARE UNIT) means that part of a Hospital specifically designed as an intensive care unit that is permanently equipped and staffed to provide more extensive care for critically ill or Injured patients than is available in other Hospital rooms or wards. Services provided include close observation by trained and qualified personnel whose duties are primarily confined to the part of the Hospital for which an additional charge is made.

LIMITING AGE for Your children is age 26.

MEDICALLY NECESSARY means that, based on generally accepted current medical practice, a service or supply is necessary and appropriate for the diagnosis or treatment of Injury or Sickness. We do not consider a service or supply as Medically Necessary if:
1. It is provided only as a convenience to the Covered Person or provider;
2. It is not appropriate treatment for the Covered Person's diagnosis or symptoms;
3. It exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment; or
4. It is Experimental or Investigational Medicine.

The fact that a Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

MENTAL DISORDER means a disease or disorder, regardless of its cause, that affects the mind or behavior. Categories of mental disorders include mood disorders, anxiety disorders, psychotic disorders, eating disorders, developmental disorders, personality disorders, and other generally accepted disorders of a similar type.

POLICYHOLDER means You, the Applicant named in the attached Application, any successor thereof, or any person named to assume ownership privileges under this Policy after the original Policyholder's death. Such person, regardless of title, has exclusive ownership privileges under this Policy. These privileges include, but are not limited to, his/her right to change coverage under this Policy for themselves or any Covered Person.

PRE-EXISTING CONDITION means a condition not otherwise excluded by name or specific description: (1) for which medical advice, testing, care, treatment or medication was given or was recommended by, or received from, a Doctor within 6 months before the Effective Date; or (2) that would have caused a reasonably prudent person to seek medical diagnosis or treatment within 6 months before the Effective Date. The Company does not cover Pre-Existing Conditions for the first 6 months of coverage.

REHABILITATION FACILITY means a specialized section of a Hospital or a properly licensed free standing facility that provides services under the direction of a Doctor that are rehabilitative or restorative; and are consistent with the standards of practice for rehabilitative medicine.

SAME DAY SURGERY FACILITY means a licensed medical facility or a part of a Hospital:

1. With an organized staff of Doctors;
2. That is permanently equipped and operated primarily for the purpose of performing surgical procedures;
3. That does not provide accommodations for overnight stays; and
4. That provides continuous Doctor services and nursing services whenever a patient is in the facility.

The term "Same Day Surgery Facility" does not include a:

1. Hospital Emergency room;
2. Trauma center; or
3. Doctor's office or Clinic.

SICKNESS means a Covered Person's illness, disease, or condition that begins after the Effective Date and while such Covered Person has coverage under this Policy. Sickness also includes an illness, disease or condition that begins before the Effective Date if it is shown on the Covered Person's Application and We have not excluded it from coverage by name or specific description. Sickness includes any complications or recurrences that relate to such Sickness while this Policy's coverage in effect for the Covered Person.

US, WE, OUR or THE COMPANY means Standard Life and Accident Insurance Company (SLAICO).

YOU or YOUR means the Applicant, named in the attached Application.

BENEFIT

In order for the Company to pay any benefit, described below, the following conditions must be met:
1. The described benefit service must begin after the Covered Person's Effective Date;
2. The described benefit service must be for the Medically Necessary treatment of a Covered Person's Injury or Sickness; and
3. The described benefit service must begin and continue while the Covered Person's coverage remains in effect under this Policy.

AMBULANCE BENEFIT – If a Covered Person requires the use of a ground or air ambulance for transportation to or from the Hospital to which the Covered Person is or was Hospital Confined, We will pay the Benefit Amount for this benefit shown in Your Policy Schedule for each ambulance trip. Benefits are also payable under this provision when the Covered Person is transported directly from a Hospital to a Rehabilitation Facility.

HOSPITAL ADMISSION BENEFIT – If a Covered Person is admitted to a Hospital and is Hospital Confined for at least one day, We will pay the Benefit Amount for this benefit shown in Your Policy Schedule. This benefit is paid in addition to any other benefits otherwise payable under the Policy. This benefit is only payable for one Hospital admission per Benefit Period for each Covered Person.

HOSPITAL CONFINEMENT BENEFIT - The Company will pay the benefit amount for this benefit shown in the Policy Schedule for each day a Covered Person is Hospital Confined, up to the Maximum Number of Days for any one Hospital Stay shown on Your Policy Schedule. The Hospital Confinement Benefit will not be paid for any day or part of a day for which the Intensive Care Unit Benefit is paid.

INTENSIVE CARE UNIT BENEFIT - The Company will pay [2] times the Hospital Confinement Benefit amount shown in Your Policy Schedule when a Covered Person is confined in an Intensive Care Unit up to a maximum of [30] days for any one Hospital Stay. The Intensive Care Unit Benefit will not be paid for any day or part of a day for which the **Hospital Confinement Benefit** is paid.

SAME DAY SURGERY FACILITY BENEFIT - If a Covered Person requires the use of a Same Day Surgery Facility, We will pay the Benefit Amount for this benefit shown in Your Policy Schedule for each day the Covered Person uses such facility

REHABILITATION FACILITY CONFINEMENT - If a Covered Person is admitted to a Rehabilitation Facility immediately following a covered Hospital Confinement of at least one day, We will pay the Benefit Amount for this benefit shown in Your Policy Schedule for each day they remain in a Rehabilitation Facility, up to 15 days per Calendar year.

EXCEPTIONS

THIS POLICY DOES NOT PROVIDE BENEFITS FOR LOSS RESULTING FROM ANY OF THE FOLLOWING EXCEPTED EVENTS.

1. Injury or Sickness that results from war or an act of war, whether war is declared or not.

2. Pregnancy and childbirth, except for Complications of Pregnancy.

3. Mental Disorders.

4. Cosmetic surgery or reconstructive surgery, including breast reduction and surgery to repair, replace, or remove breast implants; however, this Exception does not apply when surgery is required:

   a) To correct damage for a covered Injury or Sickness;
   b) To repair a birth defect of a child born to You and continuously covered under this Policy from its birth; or
   c) For reconstructive surgery following a covered mastectomy.

5. Dental Treatment, unless due to Injury to a Covered Person's natural teeth.

6. A Pre-Existing Condition as defined in this Policy.

7. Any attempt at suicide, while sane or insane.

8. An intentionally self-inflicted Injury, while sane or insane.

9. A Covered Person's commission of or attempt to commit a felony, an illegal act, or being engaged in an illegal occupation.

10. A Covered Person being intoxicated, unless such intoxication is the result of a prescription drug taken as prescribed by a Doctor.

11. A Covered Person with a blood alcohol concentration equal to or in excess of .08 gms/dl operating any motor vehicle, including any off-road vehicle; or watercraft.

12. Weight reduction or treatment of obesity, including exogenous, endogenous, or morbid obesity; .

13. Treatment provided outside the United States of America, its possessions and territories.

14. Routine newborn care.

15. Any charges for or relating to: artificial insemination; in-vitro fertilization or any other diagnosis or treatment for the control, promotion, or enhancement of fertility; treatment for impotency; sterilization or reversal of prior sterilization; abortion, unless the life of the mother would be endangered if the fetus were carried to term; or therapeutic abortion.

16. Treatment of alcoholism or drug use.

AUTOMATIC COVERAGE OF NEWBORN AND ADOPTED CHILDREN

A child born to or adopted by You will become a Covered Person under this Policy.

Newborns: Coverage for newborn children is free for the fist 90 days from the date of birth.

Adopted Children: Coverage for adopted children is free for the first 60 days of the filing of a petition for adoption if You apply for coverage within 60 days after the filing of the petition for adoption. The coverage is free for the first 60 days from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the minor.

In order to continue coverage for a newborn or adopted child, You must do the following:

1. Send Us notice of the child within the 90 days after the date of the child's birth or before the premium due date, whichever is later (or, in the case of an adopted child, within the 60 days after the filing of the petition for adoption or birth of child); and
2. Send Us the additional premium for the child within 90 days of the child's date of birth or within 60 days of the date of petition for adoption or birth of the child.

As long as You pay the extra premium, the child will remain a Covered Person, subject to the Termination of Coverage and Loss of Coverage Eligibility provisions of this Policy. Coverage for a child that is placed with You for adoption will continue in accordance with the Termination of Coverage and Loss of Coverage Eligibility provisions, unless the placement is disrupted prior to legal adoption and the child is removed from placement.

We do not require an application for the child unless You have notified Us of the child later than the timeframe as required above.

TERMINATION OF COVERAGE

We can terminate coverage under this Policy as of any premium due date under any of the following conditions:

1. You have failed to pay premiums in accordance with the terms of this Policy, or We have not received timely premium payments;
2. You or a Covered Person has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in applying for coverage or under the terms of this Policy, subject to the paragraph titled **MISSTATEMENTS IN THE APPLICATION** under General Provisions; or
3. A Covered Person ceases to be eligible for continued coverage under this Policy as described in the section titled **LOSS OF ELIGIBILITY**.

LOSS OF ELIGIBILITY

Eligibility for continuation of coverage under this Policy by a Covered Person ends on the date of the month that coincides with the date of the month shown on the Policy Schedule and occurs on such date next following the date of the event that causes such termination.

RULES FOR ALL COVERED PERSONS - Coverage will end:

1. If this Policy is terminated in accordance with the section titled **TERMINATION OF COVERAGE**; or
2. If You fail to pay the required premium within the Grace Period.

RULES FOR ADULT COVERED PERSONS - Coverage will end:

1. For Your spouse if there is a divorce;
2. If a mentally or physically disabled Covered Person marries or becomes capable of self-support; or
3. If Your spouse is not a Covered Person at the time of his/her death, We will end coverage for all Covered Persons.

If You are married and die and Your spouse is a Covered Person, Your spouse will become the Policyholder.
RULES FOR CHILD COVERED PERSONS - Coverage will end for a child when:

1. The child is no longer a dependent of Yours;
2. The child gets married;
3. The child attains the Limiting Age, except for the extension allowed by the section titled **EXTENSION OF COVERAGE FOR SOME CHILDREN**; or
4. Neither You nor Your spouse remains covered under this Policy.

PREMIUM – We will adjust premiums if required under Our rules as of the date coverage ends for a Covered Person. This will occur on a date consistent with the date coverage ends, as described above.

EXTENSION OF COVERAGE FOR SOME CHILDREN

When a dependent child who is a Covered Person that has reached the Limiting Age, coverage may continue if the child is, and remains, incapable of self-sustaining employment, by reason of mental or physical handicap, and is chiefly dependent upon You for support and maintenance. The child will continue as a Covered Person if You:

1. Send written proof of the child's incapacity no later than 31 days after the premium due date which coincides with or next follows the child's attainment of the Limiting Age;
2. Furnish, upon request, proof of the child's incapacity and dependency during the two years following the child's attainment of Limiting Age;
3. Furnish proof of the child's incapacity and dependency once a year after the two-year period described in 2 above; and
4. Pay the premium for the child. This will be on the same basis as that for an adult of like age and sex. Extension of coverage will not continue for any child named in the Enrollment Application whose disabling condition existed prior to the Effective Date of such child's coverage and was not disclosed in the Enrollment Application.

CONVERSION PRIVILEGE

If coverage under this Policy has been terminated, Covered Persons may be entitled to have a conversion policy issued by SLAICO that provides coverage similar to this Policy, without evidence of insurability, subject to the following terms and conditions.

A conversion policy is not available to a Covered Person if termination of his insurance under this Policy occurs:

1. Because he failed to make timely payment of any required premium; or
2. For any other reason, and he had not been continuously covered under this Policy, and for similar benefits under any policy which it replaced, during the entire three (3) months period ending with such termination; or
3. Because this Policy terminated and the insurance was replaced by similar coverage under another policy within thirty-one (31) days of the date of termination; and
4. Written application and the first premium payment for the conversion policy shall be made to SLAICO not later than thirty-one (31) days after such termination.

The premium for the conversion policy shall be determined in accordance with SLAICO's table of premium rates applicable to the age and class of risk of each person to be covered under that policy and to the type and amount of insurance provided.

The conversion policy shall cover the Covered Persons on the date his/her coverage terminates under this Policy. At the option of SLAICO, a separate conversion policy may be issued to cover any dependent.

The conversion policy will not exclude, as a Pre-Existing Condition, any condition covered by this Policy; provided, however, that the conversion policy may provide for a reduction of its benefits by the amount of any such benefits payable under this Policy after the individual's insurance terminates.

GENERAL PROVISIONS

ENTIRE CONTRACT -- The Entire Contract will consist of:

1. This Policy;
2. Your Application and attached papers; and
3. Any riders, endorsements or amendments issued with or added to this Policy.

We will deem all the statements provided in any attached Application and attached supplements, except fraudulent statements, as representations and not warranties.

TIME LIMIT ON CERTAIN DEFENSES --

1. MISSTATEMENTS IN THE ENROLLMENT APPLICATION --
After 1 year from the date a Covered Person becomes insured under this Policy, We may only use fraudulent misstatements in the Enrollment Application to void coverage under this Policy or to deny any claim for loss incurred after such 1 year period.

2. PRE-EXISTING CONDITIONS --
No claim for loss incurred after 6 months from the Effective Date will be reduced or denied because a Sickness or Injury, not excluded by name or specific description before the date of loss, existed 6 months before the Effective Date.

REINSTATEMENT -- Coverage terminates if You do not pay a periodic premium payment before the end of the Grace Period. Our later acceptance of premium, (or one of our authorized agent's acceptance of premium) without requiring an application for reinstatement, reinstates coverage under this Policy.

We will require an application for reinstatement. We will subject all representations made in this application to all of the provisions of this Policy, including TIME LIMIT ON CERTAIN DEFENSES. If We approve the application for reinstatement, We will reinstate coverage as of the approval date of the reinstatement Enrollment Application. If We do not approve the reinstatement and do not notify You in writing of the disapproval, We must reinstate coverage. The reinstatement will take place on the 45th day following the date of Our receipt of the application for reinstatement.

The reinstated plan only covers loss resulting from:

1. Injury that occurs after reinstatement; and
2. Sickness that begins ten days or more after the Covered Person's date of reinstatement.

In all other respects, the Covered Person's rights and Our rights will remain the same, except as stated in any application attached to the reinstated coverage.

We will apply any premiums that We accept for reinstatement to a period for which You have not paid premiums. We will not apply any premium to any period more than 60 days before the reinstatement date.

WE WILL NOT CONSIDER A REQUEST FOR REINSTATEMENT THAT YOU MAKE MORE THAN 180 DAYS AFTER YOUR COVERAGE UNDER THIS POLICY HAS TERMINATED.

GRACE PERIOD -- There is a 31 day grace period for the payment of any premium. If a renewal premium is not paid on or before its due date, it may be paid during the following 31 days. If We do not receive the payment during this Grace Period, We will terminate coverage. Termination will be effective as of the end of the period for which premium was paid.

NOTICE OF CLAIMS -- A claimant must give notice of claim within 30 days after a covered loss starts or as soon as reasonably possible. The claimant must give the notice to Us at Our Home Office in Galveston, Texas. The notice must include the claimant's name and his/her Policy Number.

CLAIM FORMS -- When We receive notice of claim, We will send the claimant forms for filing Proof of Loss. If We do not mail the claimant these forms within 15 days of Our receipt of his/her request, the claimant will have met the Proof of Loss requirement. However, the claimant must still give Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

PROOFS OF LOSS -- The claimant must give written Proof of Loss to the Home Office in Galveston, Texas within 90 days after such loss. If it was not reasonably possible for the claimant to give the Proof of Loss in the time required, We will not reduce or deny the claim as long as the claimant gives proof as soon as reasonably possible. In any event, the claimant must give proof no later than 1 year from the time specified, unless the claimant was legally incapacitated.

TIME FOR PAYMENT OF CLAIMS -- All benefits payable under this Policy will be paid upon Our receipt of Proof of Loss.

PAYMENT OF CLAIMS -- We will pay Policy benefits to You. If You have died, We will pay any unpaid benefits to Your estate. We may pay benefits up to [$1,000] to someone related to You by blood or marriage or to any other person We deem entitled to the benefits if:

1. A court has deemed You incompetent; or
2. You have died and Your estate is not able to execute a valid release.

NO ASSUMPTION OF LIABILITY -- Our payment of any claim does not mean We have assumed liability for future payments for the same condition or any related condition once:

1. We determine that no covered loss occurred; or
2. We determine that Our payment was erroneous or inappropriate.

PHYSICAL EXAMINATIONS -- We have the right to have any Covered Person examined as often as reasonably required while a claim is pending for that person. We will pay for the requested physical examination.

LEGAL ACTIONS -- No legal action may be brought to recover on this Policy within 60 days after a claimant gives written Proof of Loss. No legal action may be brought after 3 years from the time this Policy requires written proof of loss.

LIMITATION OF LIABILITY -- You agree that Our maximum liability under this Policy and related matters is limited to:

1. Policy benefits otherwise payable;
2. Your reasonable attorneys fees, if any; and
3. Any statutory penalties that may be imposed.

MISSTATEMENTS OF AGE -- If a Covered Person has misstated his age, the benefits will be those the premium paid would have purchased if the correct age had been disclosed. However, if on the Effective Date, We would not have granted coverage because of the Covered Person's correct age, We are only liable for the return of any premiums paid on account of such person.

CONFORMITY WITH STATE STATUTES -- Any provision of this Policy which, on the Effective Date, is in conflict with the laws of the state in which You reside is amended to conform to the minimum requirements of the laws of such state.

ILLEGAL OCCUPATION -- We will not be liable for any loss that results from a Covered Person engaging in an illegal occupation or committing or attempting to commit a felony.